MONTANA
TEACHERS' RETIREMENT SYSTEM

1500 E 6TH AVE
PO BOX 200139
HELENA MT 59620-0139
(406) 444-3134

TRS Office Use Only

VERIFICATION OF SUBSTITUTE TEACHING OR TEACHERS' AIDE SERVICE

(PLEASE TYPE OR PRINT LEGIBLY IN DARK INK.)

Part I – To Be Completed By Member

Member's Information:

_____ (Name)

_____-_____-_____ (Date of Birth)

☐☐☐ ☐☐ ☐☐☐☐ (Social Security Number)

_____
(Home Mailing Address)

_____
(City, State & Zip Code)

(_____)_____–_____
(Area Code & Telephone Number)

_____
(Maiden Name)

_____
(Signature)

_____-_____-_____
(Date)

Part II – To Be Completed By Certifying Official

The information below must be secured from each school district in which the member worked.

Term of Service During Each Fiscal Year (Fiscal Year - July 1 to June 30) From Month	From Year	To Month	To Year	Total Days or Hours Worked	Daily or Hourly Rate of Pay	Gross Salary Earned

If more space is needed for verification, please attach an additional sheet.

Signature of Certifying Official	Date - -	Printed Name and Title of Certifying Official
Name of Employing Agency (School, District, College, etc)		Employing Agency Mailing Address
Employing Agency Area Code & Telephone Number ( ) –		City, State, & Zip Code

NOTE: After completing this form, please return it to the Montana Teachers' Retirement System at the above address.

IN COMPLIANCE WITH THE AMERICANS WITH DISABILITIES ACT OF 1992,
ALTERNATIVE ACCESSIBLE FORMATS OF THIS DOCUMENT WILL BE PROVIDED UPON REQUEST